California Public Employees' Retirement System
Proposed Amendment to Title 2, California Code of Regulations
Proposed New Section 599.517

FINDING OF EMERGENCY

The Board of Administration (Board) of the California Public Employees' Retirement System (CalPERS) finds that an emergency exists and that the addition of section 599.517 to Title 2, California Code of Regulations is necessary for the immediate preservation of the public health and general welfare. The section will be contained in Title 2, Division 1, Chapter 2, Subchapter 3 of the California Code of Regulations, which implements and interprets the Public Employees' Medical and Hospital Care Act (PEMHCA), Government Code section 22751, et seq.

Pursuant to its authority under PEMHCA, through contracts with carriers and two self-funded plans, the Board provides healthcare coverage for over 1 million employees and annuitants (and their family members) of the state and school and public agency employers that have elected to participate in PEMHCA.

The Board finds that the situation the attached proposed language is intended to address meets the requirement for emergency based on the following:

1. The state and contracting agencies will incur additional and avoidable health benefit costs if Medicare-eligible annuitants, in direct violation of the provisions of Government Code section 22819, remain enrolled in a basic health plan. Annuitants utilize health benefit services at higher levels than employees. Increased use directly impacts the cost of a basic health plan resulting in higher premium amounts. The termination of Medicare-eligible annuitants from enrollment in a basic health plan reduces the utilization of basic health plans and thereby reduces premiums paid by employers, employees, and annuitants not eligible for Medicare. Savings from such terminations are twofold: First, lower premiums result in lower state and contracting agency costs since, for example, the state (subject to collective bargaining) ordinarily pays 80 percent of the weighted average of the premiums for the four health plans with the largest enrollment for employees and their family members. Second, lower basic health plan premiums result in lower state and contracting agency contribution rates for annuitants not eligible for Medicare.

2. Required enrollment of Medicare-eligible annuitants into Medicare properly places financial responsibility for Medicare covered services on Medicare. This results in direct savings especially to CalPERS self-funded health plans since Medicare, and not the plans, would be responsible for all Medicare covered services. For example, CalPERS' self-funded plans are only responsible for 20 percent of the costs of an annuitant's health care services if the annuitant is enrolled in a Medicare supplemental plan. Conversely, a Medicare-eligible

annuitant *not* enrolled in a supplemental plan requires CalPERS to pay 80-90 percent of the cost of that annuitant's health care services.

3. Increased health benefit costs for the enrollment of Medicare-eligible annuitants in a basic health plan impacts a contracting agency's decision to participate in CalPERS health programs. Inflated basic health plan premiums cause contracting agencies to withdraw from CalPERS health programs to seek lower cost coverage for employees which in turn could result in a reduction in the size and stability of the CalPERS health care purchasing pool.

4. Increased costs to the state and contracting agencies based on improper enrollment of Medicare-eligible annuitants into a basic health plan could impact total enrollment in CalPERS provided health plans. Increased costs to the state and contracting agencies are passed on as an increased basic health plan premium and could result in employees and annuitants not eligible for Medicare being unable to afford their payment obligations for a basic health plan. As a result, employees and annuitants not eligible for Medicare may cancel their enrollment in a CalPERS basic health plan and go without health care coverage.

5. The proposed regulation will encourage timely enrollment of Medicare-eligible annuitants into Medicare Part B which will help members avoid federally imposed penalties for late enrollment.

Background

Recent increases in health benefit premiums have caused CalPERS to examine member enrollment trends and fiscal policy issues related to employee/annuitant health care in order to ensure the most effective and efficient health benefit plan administration. As a result, the Board determined that the continued enrollment of Medicare-eligible annuitants in its basic health plans fails to comply with Government Code Section 22819, which states:

> Employees, annuitants, and their family members who become eligible on or after January 1, 1985, for Part A and Part B of Medicare shall not be enrolled in a basic health benefits plan. If the employee, annuitant, or their family member is enrolled in Part A and Part B of Medicare, he or she may shall enroll in a supplement to Medicare plan. This section shall not apply to employees and family members which are specifically excluded from enrollment in a supplement to Medicare plan by federal law or regulation.

Based on this finding and in furtherance of its fiduciary duty to all health benefit plan members, the Board approved the attached emergency regulations to enforce Section 22819. These regulations are necessary at this time because the Board has determined that the continued enrollment of Medicare-eligible annuitants in the basic health plan constitutes an immediate adverse impact to all basic plan enrollees and their employers. These regulations establish a procedure to support and enforce Section

22819, clearly communicate CalPERS' expectations to annuitants, and properly coordinate Medicare rules and regulations.

Under federal law, in order to be eligible for enrollment in a Medicare-coordinated health plan or a Medicare risk plan such as those administered or contracted for by the Board, an annuitant must have both Medicare Part A and Part B coverage. Part A (hospital insurance) is provided at no cost to individuals who have worked and paid into Social Security for a specified number of quarters. Individuals who are eligible for Part A are automatically enrolled. Part B (medical insurance) is available to all individuals upon turning age 65. There is a charge for this coverage and an annuitant must enroll in Part B. The initial enrollment period is seven (7) months and begins three (3) months prior to the individual's 65th birthday. An annuitant who does not enroll upon turning 65 may only enroll during a subsequent open enrollment period.

The proposed regulation provides, among other things, the new communication efforts to ensure that annuitants receive timely and unambiguous notification of their responsibility to inform CalPERS of their Medicare eligibility and coordinate enrollment, if appropriate. Thus, if annuitants are *not* eligible for Medicare, it is their responsibility to inform CalPERS of this fact in order to prevent cancellation of their health benefits coverage. If annuitants *are* eligible for Medicare, in order to maintain continued health benefit coverage through CalPERS, they must enroll in Part B and coordinate timely enrollment in one of CalPERS Medicare-coordinated or Medicare risk plans. This will ensure compliance with Government Code section 22819.

AUTHORITY AND REFERENCE

Government Code section 22773 grants the Board "all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed upon it" under PEMHCA.

Government Code section 22819 specifically prohibits employees, annuitants, and their family members from continued enrollment in a basic plan upon becoming Medicare-eligible.

In addition, Government Code section 22775 empowers the CalPERS Board to adopt all necessary rules and regulations to carry out the provisions of PEMHCA "including but not limited to establishing the scope and content of a basic health benefits plan, regulations fixing reasonable minimum standards for health benefits plans, regulations fixing the time, manner, method and procedures for determining whether approval of any plan should be withdrawn, and regulations pertaining to any other matters it may be expressly authorized or required to provide for by rule or regulation by the provisions of this part." When adopting such rules and regulations, section 22775 directs the Board to "be guided by the needs and welfare of individual employees, particular classes of employees, and of the State, as well as prevailing practices in the field of prepaid medical and hospital care."

The attached regulation would implement, interpret and make specific Government Code section 22819.

INFORMATIVE DIGEST

This proposed action would implement, interpret and make specific Government Code section 22819 by establishing a process to prevent continued enrollment in a basic plan by those employees, annuitants, and their family members whom are Medicare-eligible.

Thus, the proposed regulations would enforce Government Code Section 22819 by establishing a process for terminating basic health plan enrollment of annuitants who are eligible for, but otherwise refuse to enroll in Medicare Parts A and B.

OTHER STATUTORY REQUIREMENTS

There are no additional rulemaking requirements specific to CalPERS, this specific regulatory action or this type of regulation.

LOCAL MANDATE DETERMINATION

The proposed regulatory action imposes no mandate on local agencies.

FISCAL IMPACT

The proposed regulatory action has no cost impact to any local agency or any school district that must be reimbursed under Government section 17500.

The proposed regulatory action imposes no non-discretionary cost on local agencies.

The proposed regulatory actions have no cost impact to any state agency.

The proposed regulatory action has no cost impact to any federal funding to the state

Section 599.517. Termination of Enrollment in Basic Health Benefits Plan for Failure to Enroll In Part A and Part B of Medicare

Except as otherwise provided under federal law or regulation, employees, annuitants and their family members who, on or after January 1, 1985, become Medicare-eligible, as defined below, may not be enrolled in a basic health benefits plan. Failure of a Medicare-eligible basic plan member to enroll in Part B of Medicare and in a Medicare Plan will result in termination of basic plan coverage.

(a) As used in this section and in Government Code section 22819:

(1) "Post-1997 Basic Health Plan Enrollees" means those annuitants and their family members who (a) have been continuously enrolled in a basic health benefits plan on or after January 1, 1998, and (b) turned 65 on or after January 1, 1998 and before January 1, 2005.

(2) "Prospective Medicare Beneficiary" means an annuitant, employee or family member who is enrolled in a basic health benefits plan and, at the time of notification hereunder, is within the Medicare Initial Enrollment Period.

(3) "Medicare-Eligible" means eligible for Medicare Part A without cost and Part B.

(4) "Medicare Plan" means a Medicare supplement or Medicare-risk health benefits plan approved or contracted for by the board.

(5) "Deferral of Part B Enrollment" means deferral of Part B enrollment by a Medicare-eligible state or a contracting agency employee who, pursuant to federal law and regulations, has deferred enrollment in Part B of Medicare because he or she is actively employed and covered by a basic health benefits plan by virtue of that employment.

(b)Enrollment and continuation in a basic health benefits plan.

(1) Except as set forth below, Post-1997 Basic Health Plan Enrollees and Prospective Medicare Beneficiaries who are Medicare-eligible may not continue to be enrolled in a basic health benefits plan.

(2) A Medicare-eligible individual who applies for initial enrollment in a basic health benefits plan, or re-enrollment after a break in coverage, shall not be permitted to enroll in a basic plan notwithstanding the fact that he or she was enrolled in an employer-sponsored basic health plan prior to, or on the date of, the application for enrollment.

(3) A Medicare-eligible state or contracting agency employee who has deferred his or her enrollment in Part B, may continue to be enrolled in a basic health benefits plan until the earlier of retirement or termination of employment. Such employee must notify the Board immediately upon termination of his or

her deferred status and must enroll in Part B of Medicare during his or her special enrollment period.

(c) Notice of Requirement to Enroll in Medicare.

(1) Post-1997 Basic Health Plan Enrollees. No later than December 1, 2004, the Board shall provide notice to Post-1997 Basic Health Plan Enrollees of their requirement to enroll in Part B of Medicare. This notice shall provide that (a) if they are Medicare-eligible they may not remain in a basic plan, (b) if they are eligible for Part A of Medicare without cost, they must enroll in Part B of Medicare and in a Medicare Plan in order to retain health plan coverage; and (c) the failure to provide the board with satisfactory evidence of enrollment in Part B, ineligibility for Part A without cost, or deferral of Part B enrollment will result in the termination of their basic plan enrollment.

(2) Prospective Medicare Beneficiaries. Commencing four (4) months prior to a Prospective Medicare Beneficiary's 65th birth month, the Board shall provide notice of the requirement to enroll in Medicare. This notice shall inform the Prospective Medicare Beneficiary that if he or she is Medicare-eligible, he or she may not remain in a basic health benefits plan and must timely enroll in Part B of Medicare and a Medicare Plan in order to retain health plan coverage. The notice shall also inform the Prospective Medicare Beneficiary that failure to provide the board with satisfactory evidence of enrollment in Part B, ineligibility for Part A of Medicare without cost, or deferral of Part B enrollment will result in the termination of his or her basic plan enrollment.

(d)Termination of enrollment in a basic health benefits plan.

(1) On or before March 31, 2005, Post-1997 Basic Health Plan Enrollees shall provide the Board with satisfactory evidence of application for enrollment in Part B of Medicare during the 2005 Medicare open enrollment period, ineligibility for enrollment in Part A of Medicare without cost, or deferral of Part B enrollment. Failure to do so will result in termination of basic plan enrollment effective April 1, 2005.

(2) On or before June 1, 2005, a Post-1997 Basic Health Plan Enrollee who applied to enroll in Part B of Medicare during the 2005 open enrollment period shall provide the Board with satisfactory evidence of enrollment in Part B of Medicare and an application for enrollment in a Medicare plan. Failure to do so will result in termination of basic plan enrollment effective July 1, 2005.

(3) The basic plan enrollment of a Prospective Medicare Beneficiary who fails to provide to the Board satisfactory evidence of enrollment in Part B of Medicare, ineligibility for Part A of Medicare without cost, or deferral of Part B enrollment by the last day of his or her birth month, will be terminated effective the first of the subsequent month.

(4) To the full extent permitted by law, the Board shall have no liability for any costs, losses or damages incurred by any person as a result of, or arising from or related to, the termination of basic health benefits plan coverage in accordance with this section.

(e) Enrollment in a Supplemental Plan.

(1) Post-1997 Basic Health Plan Enrollees and Prospective Medicare Beneficiaries who are Medicare-eligible may enroll in a Medicare Plan by submitting an application to the Board and proof of enrollment in Parts A and B of Medicare. Enrollment in the Medicare Plan shall be effective on the date Medicare coverage became effective or the first of the month following receipt of the application, whichever is later.

(2) Notwithstanding (1) above, a person whose coverage has been terminated pursuant to subsection (d) and who subsequently submits evidence of enrollment in Parts A and B of Medicare may only enroll in a Medicare Plan under the following conditions:

(A) If the application and proof of enrollment in Parts A and B of Medicare are submitted within 90 days of the date that basic plan coverage terminated, enrollment in the Medicare Plan shall be retroactive to the effective date of Medicare coverage or a date 90 days prior to the submission of evidence of Medicare enrollment, whichever is later.

(B) If the application and proof of enrollment in Parts A and B of Medicare are submitted more than 90 days after the date that basic plan coverage terminated, the effective date of enrollment shall be the first of the month following receipt of the application or, if applicable, the effective date of coverage under open enrollment.

(f) Enrollment in a basic health benefits plan after termination.

If a person whose basic plan coverage has been terminated pursuant to subsection (d) subsequently submits satisfactory written confirmation that he or she is either not eligible for Part A of Medicare without cost or has deferred enrollment in Part B of Medicare, he or she may enroll in a basic health benefits plan under the following conditions:

(1) If the documentation is received by the Board within 90 days of the date that coverage terminated, re-enrollment in a basic plan shall be retroactive to the date coverage terminated.

(2) An application for enrollment received more than 90 days after basic plan coverage has terminated may be submitted only during a CalPERS Health Benefits Open Enrollment period.

(g) Request for administrative review – termination of enrollment in basic health benefits plan.

(1) A person who has been notified that his enrollment in a basic plan has, or will be, terminated pursuant to subsection (d), may request an administrative review of the termination. The filing of a request for administrative review shall not delay the termination of basic plan enrollment.

(2) A request for administrative review must be filed with the Health Branch Assistant Executive Officer within 90 days of the termination date or the date of the notice of termination, whichever is later. The request for administrative review shall be in writing, state the grounds on which it is requested, the relief that is sought, and include all supporting evidence.

(3) The Health Branch Assistant Executive Officer or his or her designee shall acknowledge the request within 15 days of receipt. The Health Branch Assistant Executive Officer or his or her designee shall review the request and may request additional documentation. Written notification of the decision shall be mailed within 60 days of receipt of all pertinent information.

(h) Request for administrative review – effective date of Medicare Plan enrollment.

(1) A person whose enrollment in a Medicare Plan is delayed pursuant to subsection (e)(2)(B) due to failure to timely submit evidence of enrollment in Part B of Medicare, may seek administrative review of the basis for the delayed effective date. The filing of a request for administrative review shall not delay the termination of basic plan enrollment.

(2) A request for administrative review must be filed with the Health Branch Assistant Executive Officer within 90 days of the notice of the effective date of enrollment in the Medicare Plan. The request for administrative review shall be in writing, state the grounds on which it is requested, the relief that is sought, and include all supporting evidence.

(3) The Health Branch Assistant Executive Officer or his or her designee shall acknowledge the request within 15 days of receipt. The Health Branch Assistant Executive Officer or his or her designee shall review the request and may request additional information. Written notification of the decision shall be mailed within 60 days of receipt of all pertinent information.

NOTE: Authority cited: Sections 22773 and 22775, Government Code
Reference: Section 22819, Government Code